MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes ( ) No
Requestor's Name and Address Wol + Med / Ed. Wolski, M.D. 2436 IH 35 East South, Ste. 336 Denton TX 75205	MDR Tracking No.: M4-03-7187-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 42 American Manufacturers Mutual. Ins. c/o Harris & Harris PO Box 162443 Westlake Station Austin TX 78716	Date of Injury: Employer's Name: Toms Foods, Inc. Insurance Carrier's No.: 4650151581

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
6/12/02	**9/12/02**	**E1399 x 4**	**$340.00**	**$340.00**
7/10/02	**9/17/02**	**99213 x 2**	**$96.00**	**$48.00**
			TOTAL DUE:	**$436.00**

PART III: REQUESTOR'S POSITION SUMMARY

6/24/03: "Our Positon: We feel the carrier has failed to comply with…taking final action on a medical bill not later than the 45th day after the date the insurance carrier received a complete medical bill…sending payment that makes the total…fair and reasonable reimbursement…carrier shall treat a request for reconsideration as an incomplete medical bill…within 21 days of receiving the request…shall take final action…"

PART IV: RESPONDENT'S POSITION SUMMARY

The respondent's representative submitted EOB's with the following audits:

* CPT code E1399: DOS: 6/12/02 - Date of Audit: 8/ 6 /03
7/12/02 - Date of Audit: 7/24/03
8/12/02 - Date of Audit: 7/14/03
9/12/02 - Date of Audit: 7/14/03
All DOS for the TENS supplies indicated full reimbursement.

* PT code 99213: DOS: 7/10/02 & 9/17/02 - Dates of Audit: 7/14/03 Shows reimbursement per "F-fee guideline @ MAR.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT code E1399, for DOS 6/12/02, 7/12/02, 8/12/02, and 9/12/02 appeared to have been reimbursed in full, without reduction according to the EOB's. The Date Paid, and Paid Amounts were not indicated on the EOB's. Therefore, due to the dates of the audits, according to rule 133.307 (i), and incomplete information per rule 133.307 (j)(1 & 2), reimbursement per MFG/ DME/ GR X (C), is recommended.

  Amount due = $85.00 x 4 days = $340.00.
- CPT code 99213, for DOS 7/10/02 & 9/17/02 per the EOB, appeared to have been reimbursed per MAR. Due to the dates of the audits, according to rule 133.307 (i), and incomplete information per rule 133.307 (j)(1 & 2), reimbursement recommended. Amount due = $48.00 x 2 days = $96.00.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $436.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Name	4/21/05 Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite #100, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____